ATTACHMENTS

Nos. 1 - 13

ATTACHMENT No. 1

NHCPC BYLAWS

NEBRASKA HIV CARE and PREVENTION CONSORTIUM
BYLAWS

ARTICLE I. NAME

The name of the Advisory Group shall be Nebraska HIV CARE and Prevention Consortium (hereinafter referred to as the NHCPC).

ARTICLE II. MISSION

The overall mission of the NHCPC is to develop a comprehensive HIV CARE and Prevention Plan for the State of Nebraska. The plan will identify specific strategies and interventions that are responsive to validated needs within defined target populations.

This mission will be accomplished in an advisory capacity in collaboration with the Nebraska Department of Health & Human Services System (HHS), the National Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA).

ARTICLE III. STATEMENT OF PURPOSE

1. Assess the present and future extent, distribution, and impact of HIV prevention and care issues in defined populations in the state.
2. Identify and prioritize high-risk populations based on formal and informal epidemiological information.
3. Assess HIV care and prevention needs through the identification of existing care and prevention services, as well as gaps and barriers within defined populations.
4. Identify, prioritize, and recommend care and support services as well as adequacy for defined services.
5. Identify and recommend specific strategies and interventions to prevent new HIV infections in defined populations. These interventions should be based on sound behavioral change theory and cost effectiveness.
6. Ensure parity, inclusion, and representation reflective of the HIV epidemic within the community prevention planning as well as incorporated into CARE related decisions.
7. Develop a Comprehensive HIV Prevention Plan consistent with the high priority HIV care/support and prevention needs for defined target populations. Annually review and modify this plan as necessary.
8. Review and endorse Statewide Coordinated Statement of Need, incorporating information required per HRSA agreement.
9. Evaluate the effectiveness of the planning process.

The HHS HIV Program will develop applications for federal funds for HIV care and prevention based on the Comprehensive HIV CARE and Prevention Plan. The NHCPC will be asked to assess the responsiveness and effectiveness of funding applications in addressing the priorities identified in the Comprehensive HIV CARE and Prevention Plan.

ARTICLE IV. MEMBERSHIP

Section 1. A member is an individual occupying a standing or elected position on the NHCPC. Only members have voting privileges. The membership of the NHCPC advisory group shall be geographically balanced and reflect the diversity of the HIV epidemic. Recruitment shall be guided by the principles of parity, inclusiveness, and representation, as established by CDC in Section 1.3.2.1, CDC Criteria, Handbook for HIV Prevention Community Planning (Addendum B) and Public Law 101-381.

Section 2. There shall be two classifications of members:

a. Appointed/standing members will be comprised of related state agencies and others recommended to serve in order to balance CDC requirements. Standing members will comprise no more than 1/3 of the total membership.
b. Elected members will represent related functional areas, persons directly impacted by the epidemic, and geographic representation. Elected representatives shall comprise the remaining 2/3 of the membership.

Section 3. Any member may resign at any time from service on the NHCPC by submitting a written resignation to either the State or Community Co-Chair.

Section 4. Any member, elected or standing, determined to be in violation of the NHCPC Code of Conduct, contained in the Operational Guidelines, or in violation of a signed Disclosure of Conflict, may be removed by a majority vote at a meeting at which quorum is present. Any active member may report violations. Violations should be submitted in writing to either the Chair or State Liaison of the Membership Committee for presentation to the full membership no less than 30 days prior to the next regularly scheduled meeting.

ARTICLE V. TERMS OF MEMBERSHIP

Section 1. Members will serve for a period of 3 years (36 months) with the following exceptions: 1) Standing Members and 2) Circumstances identified in ARTICLE VII Sections 4 and 5.

Section 2. Members are elected at the last official NHCPC meeting of the calendar year and take office on January 1 of the following year. Terms expire on December 31.

Section 3. Members of the NHCPC may not serve more than two consecutive terms.

Section 4. Standing member positions are designated per requirements for the CDC and HRSA. Appointments to these positions will be at the discretion of the HIV Program Administrator.

ARTICLE VI. OFFICERS

Section 1. The NHCPC will be directed by two co-chairs. The State Co-Chair will be appointed by the HIV Program Administrator. The second, Community Co-Chair, will be elected by the NHCPC membership at the third official meeting of the calendar year and will take office on January 1 of the following year. Terms expire on December 31.

Section 2. The Community Co-Chair term shall be for a period of two years. He/she shall not serve more than two consecutive terms. A Community Co-Chair must have been a member of the NHCPC for six months prior to election.

ARTICLE VII. EXECUTIVE COMMITTEE

The purpose of the Executive Committee is to carry on the business of the NHCPC between meetings as necessary. The duties of the Executive Committee would be limited, but would include:

- Periodic review of the Bylaws and Operational Guidelines
- Review and concurrence of the annual CDC application
- Development of the Nebraska HIV Comprehensive Plan

Members of the Executive Committee will be the State and Community Co-Chairs and the Standing Committee Chairs.

ARTICLE VIII. VACANCIES

Section 1. Should a regional representative to the NHCPC be unable to serve an entire term, the recognized area HIV prevention and/or care group shall select another representative. Should no area group exist, the NHCPC Membership Committee shall solicit/recruit an appropriate representative for the designated area. A recognized area HIV prevention and/or care group shall be defined as any formal body created or acting as a subcommittee to such a body, with the documented purpose of addressing HIV prevention and/or care issues through a mission statement, statement of purpose, and defined goals and objectives.

Section 2. Should any other non-standing member to the NHCPC be unable to serve an entire term, another representative shall be recommended by the Membership Committee and voted on by the full NHCPC membership following established principles of parity, inclusion, and representation.

Section 3. Should a standing member to the NHCPC be unable to serve an entire term, another representative shall be appointed by HIV Program Administrator.

Section 4. If a vacancy occurs before half (less than 18 months) of the NHCPC member's term has been served, the person who fills that vacated position will have the same term expiration date as the member who vacated the position.

Section 5. If a vacancy occurs after half of the NHCPC member's term has been served, the person who fills that vacated position will serve out the remainder of that term in addition to another 36 months.

ARTICLE IX. ATTENDANCE

Section 1. To ensure consistent participation and input, a member who has three absences within the calendar year, whether excused or unexcused, will be considered a non-participating member and will be replaced.

Section 2. A member who has two unexcused absences in a calendar year shall be considered non-participating and be replaced. The member who will be absent defines an excused absence as notification to one of the two Co-Chairs **prior** to the beginning of any regularly scheduled meeting.

Section 3. An NHCPC member may not designate a proxy to attend a meeting should he/she be unable to attend. Should the member request a representative to attend the meeting, that representative will be considered a member of the public and have no voting privilege.

ARTICLE X. MEETINGS

Section 1. The NHCPC shall hold no more than four formal meetings per calendar year.

Section 2. The NHCPC co-chairs shall set agendas for meetings. Meeting agendas will be mailed to members at least 10 days prior to the next scheduled meeting.

Section 3. All meetings are considered open meetings and as such will abide by Public Meeting Statutes, Neb. Rev. Stat. §§ 84-1414 (Reissue 1987 and Supp. 1989). Except for items of an emergency nature, the agenda shall not be altered later than 24 hours before the scheduled commencement of the meeting. The public body shall have the right to modify the agenda to include items of an emergency nature only at such public meeting.

Section 4. Minutes shall be written and available for inspection within 10 working days or prior to the next convened meeting, whichever occurs earlier. Written minutes shall be provided to all NHCPC members prior to subsequent meetings.

Section 5. It is the philosophy of the NHCPC to make decisions by consensus. Consensus is defined as all members willing to support and "sign-off" on decisions when a quorum is present. Should consensus not be achieved, voting procedures shall follow the guidelines set forth in Robert's Rules of Order. In accordance with the requirements of Nebraska's public meeting statutes, all formal decisions will be documented through roll call vote.

Section 6. A quorum is defined as 60% of the current NHCPC membership and will be established at the time of the first roll call vote.

Section 7. All NHCPC members will have voting privileges. The HHS Program will register one vote. In the event of a tie, the HIV Program Administrator will vote.

Section 8. Each member present will have one vote at the meeting. No vote by proxy will be accepted.-

Section 9. Only NHCPC members will be allowed to speak at meetings unless the Co-Chairs have included a public presentation as a part of the regular meeting agenda.

Section 10. At the end of each meeting, an open forum will be held in which members of the public may address the NHCPC with agenda-related items. Time limits for presentations may be set. All members of the public who speak must identify themselves.

Section 11. Written notice of the time and place of all NHCPC meetings shall be posted in all regional HHS offices and at two other public sites in Lincoln and Omaha at least 24 hours prior to each meeting.

Section 12. The Co-Chairs may call special meetings with at least 10 days notice by phone, fax, email, or letter. Public notice of such meetings shall follow procedures as established in Section 3.

ARTICLE XI. CONFLICT OF INTEREST

Section 1. In making recommendations to the HHS, the NHCPC must operate in compliance with all applicable state and local conflict of interest laws. In order to safeguard NHCPC recommendations from potential conflict of interest, each member shall disclose any and all professional and/or personal affiliations with agencies that may pursue funding. An annual Disclosure of Conflict of Interest Statement will be completed by each group member and kept on file. On issues where a member's affiliate is the potential recipient of funds, that member may not vote on that issue or formally review that affiliate's request for funds or other supports.

Section 2. Per Article IV., Section 4, violations by members of their signed Disclosure of Conflict of Interest Statement may be grounds for removal from membership.

ARTICLE XII. COMMITTEES AND TASK FORCES

Section 1. The NHCPC shall have the ability to create standing committees as deemed appropriate to ensure that the mission of the NHCPC is successfully met.

Section 2. Each committee shall elect a Chair to direct the activities of the committee. The Chair shall be a current member of the NHCPC.

Section 3. Committee Chair(s), with assistance from State Liaisons, shall set agendas for committee meetings and submit items for inclusion with the NHCPC agenda to either the State or Community Co-Chair no less than 20 days prior to the next convened meeting.

Section 4. All members of the NHCPC are expected to serve on a committee during their term of membership. Supporting the NHCPC philosophy of broadening community involvement to ensure parity, inclusion, and representation in all aspects of the process, persons outside the NHCPC membership may be solicited to participate on committees and ad hoc groups or task forces.

Section 5. All committee meetings will be governed by the same set of rules as established in ARTICLE VIII – ATTENDANCE and the Operational Guidelines.

Section 6. The NHCPC Co-Chairs, to fulfill time-limited objectives may, as needed, designate ad hoc groups. Chairpersons for ad hoc groups will be appointed by NHCPC Co-Chairs and will report to the NHCPC Co-Chairs for the duration of the appointment.

Section 7. The Chairperson(s) for ad hoc group(s) will be members of the NHCPC.

ARTICLE XIII. BOOKS AND RECORDS

The NHCPC shall keep minutes of all proceedings of the NHCPC and such other books and records as may be required for proper conduct of its business and affairs.

ARTICLE XIV. ADOPTION AND AMENDMENTS

Section 1. The Bylaws for the Nebraska HIV CARE and Prevention Consortium will be ratified at the first formal meeting of the NHCPC.

Section 2. These Bylaws may be amended at any regular or special meeting of the NHCPC. Written notice of the proposed Bylaws change shall be mailed or delivered to each member at least 10 calendar days prior to the date of the next regular meeting. Bylaws changes require a two-thirds majority vote of the NHCPC members present.

Section 3. All NHCPC members shall be provided a current edition of NHCPC Bylaws and Operational Guidelines. A signed Statement of Receipt and Acceptance of Bylaws and Operational Guidelines shall be kept on file.

Ratified on: 5/23/2000
Changes Approved: 1/23/2003
Changes Approved: 2/12/2004
Changes Approved: 4/22/2004
Changes Approved: 6/24/2004
Changes Approved: 8/19/2004

ATTACHMENT No. 2

NHCPC OPERATIONAL GUIDELINES

NEBRASKA HIV CARE and PREVENTION CONSORTIUM
OPERATIONAL GUIDELINES

The Nebraska Department of Health and Human Services, HIV/AIDS Program, under the requirements of Cooperative Agreements with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), has established the Nebraska HIV CARE and Prevention Consortium (NHCPC). The Nebraska HIV CARE and Prevention Consortium, henceforth referred to as the NHCPC, shall function as an advisory body to the Department's HIV/AIDS and Ryan White or Title II Programs. The following information shall be known as the Operational Guidelines for the NHCPC and shall direct the operational aspects of the NHCPC.

All members of the NHCPC shall, upon reading and signing a Statement of Receipt and Acceptance, adhere to these guidelines as a part of their membership.

I. Purpose

The purpose of the NHCPC is to act in an advisory capacity to the Nebraska Health and Human Services HIV/AIDS and Ryan White Programs. Through this advisory relationship, the HIV/AIDS and Ryan White Programs will respond to the care and prevention issues affecting those at risk for becoming HIV infected as well as those who are currently living with HIV disease through facilitating health education, risk reduction programming, public information, HIV counseling, testing, referral and partner notification, support services, AIDS Drug assistance, and treatment.

II. Organizational Structure

The NHCPC will be made up of no more than 38 members. The members will be classified as "standing" positions or "elected" positions. Standing positions are filled by persons required by federal funding and administrative recommendation to ensure specific expertise, which is critical to HIV prevention and care through public health forums. These positions will comprise no more than 1/3 of the total membership. The elected positions will represent related functional areas, persons directly impacted by the epidemic, and geographic representatives. These members comprise the remaining 2/3 of the membership.

Parity - Inclusion - Representation (P.I.R.)

Per the Centers for Disease Control and Prevention, all grantees (HHS) are required to adhere to certain principles for HIV prevention community planning. Parity, inclusion, and representation (PIR) characterize this process.

Parity is the condition where ***all*** members of the NHCPC are provided opportunities for orientation and skills building to participate in the process and to have ***equal voice*** in voting and other decision-making activities.

Inclusion is defined as the assurance that the views, perspectives, and needs of ***all affected communities*** are included, to the extent possible, and involved in a meaningful manner in the community planning process.

Representation is the assurance that those who are representing a specific community truly reflect that community's values, norms, and behaviors. These representatives must also be able to participate as group members in objectively weighing the overall priority prevention needs of the jurisdiction.

A. Geographic Representation

The large geographic area of Nebraska creates unique challenges for service providers. Successful public health initiatives in the areas of prevention and care/treatment issues require attention to service availability, gaps/barriers to services and participation by those residing in the community. The social norms, values, and resources may vary according to each area of the state and its proximity to other communities. These issues support the need for geographically diverse representation in the planning process. Issues must be prioritized based on a number of factors including economic feasibility, programmatic effectiveness, community acceptance, existing capacity for implementation, etc. These issues support the need for geographic representatives to ensure the process is inclusive of the needs of all affected Nebraskans.

For the purpose of the NHCPC, geographic representation will follow the geographic boundaries established by HHS for service delivery. These Service Areas will be designated as such:

Southeast Region (I), Counties of Butler, Cass, Fillmore, Gage, Jefferson, Johnson, Lancaster, Nemaha, Otoe, Pawnee, Polk, Richardson, Saline, Saunders, Seward, Thayer, and York
Eastern (II), Counties of Dodge, Douglas, Sarpy, and Washington
Northern (III), Counties of Antelope, Boone, Boyd, Brown, Burt, Cedar, Cherry, Colfax, Cuming, Dakota, Dixon, Holt, Keya Paha, Knox, Madison, Nance, Pierce, Platte, Rock, Stanton, Thurston, and Wayne
Central (IV), Counties of Adams, Blaine, Buffalo, Clay, Custer, Franklin, Garfield, Greeley, Hall, Hamilton, Harlan, Howard, Kearney, Loup, Merrick, Nuckolls, Phelps, Sherman, Valley, Webster, and Wheeler
Southwest (V), Counties of Arthur, Chase, Dawson, Dundy, Frontier, Furnas, Gosper, Grant, Hayes, Hitchcock, Hooker, Keith, Lincoln, Logan, McPherson, Perkins, Red Willow, and Thomas
Western (VI), Counties of Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Kimball, Morrill, Scotts Bluff, Sheridan, and Sioux

These service areas may change or vary based on state or programmatic discretion.

B. Standing Members and Elected Members

See *Section II-Organizational Structure* for definitions of members. HHS HIV Program, per recommendation needed for the "standing" categories, will determine the positions required by the CDC and HRSA. Persons identified to serve in these positions will be chosen by the HIV Program Administrator upon recommendation. The positions designated as "elected" categories will be determined by the Membership Committee of the NHCPC based on the current HIV epidemiological profile of the state and based on the principles of Parity, Inclusion, and Representation. The Membership Committee will assess the need for specific classification positions for the NHCPC periodically and will make recommendations to the full committee to coincide with future elections.

III. Member Roles

A. The Role of the NHCPC as a body will be as follows:

Prevention Related:

1. Assess the present and future extent, distribution, and impact of HIV prevention and care issues in defined populations in the state.

2. Identify and prioritize high-risk populations based on formal and informal epidemiological and needs assessment information.

3. Identify and recommend specific strategies and interventions to prevent new HIV infections in defined populations. These interventions should be based on sound behavioral and social science, cost and cost effectiveness, needs assessment, and outcome evaluation.

4. Identify the technical assistance needs of the NHCPC and community-based providers in the areas of planning, implementing, and evaluating prevention interventions as well as the NHCPC's needs to enable it to execute an effective planning process.

5. Review the HHS HIV Program application to the CDC for federal HIV prevention funds, including the proposed budget, and write a letter of concurrence or nonconcurrence.

CARE Related:

1. Assess HIV care and treatment needs for individuals and families living with HIV disease through the identification of existing care and prevention services, as well as gaps and barriers to those needs.

2. Encourage public/private partnerships in planning, developing, and providing care.

3. Encourage local decision making about what care is needed.

4. Ensure parity, inclusion, and representation reflective of the HIV epidemic in decision making and the planning process, including the involvement of affected populations.

5. Assure that care and services are provided to people regardless of their ability to pay, except where income guidelines must be applied due to funding limitations.

6. Assure that localities use CARE funds only for services as payer of last resort, assisting both rural and urban areas.

7. Establish service standards. NHCPC may assist in developing service or quality of care standards for providers.

8. Take a leadership role in assessment and evaluation of service quality, unit costs, effectiveness, and administrative efficiency of subgrantees/providers/contractors, in cooperation with providers, the lead agency, and the grantee.

Prevention and Care Related:

1. Develop a Comprehensive HIV Prevention Plan consistent with the high priority HIV care/support and prevention needs for defined target populations. Annually review and modify this plan as necessary.

2. Review and endorse Statewide Coordinated Statement of Need incorporating information required per HRSA.

3. Evaluate the effectiveness of the planning process.

IV. Responsibilities between NHCPC and HHS

A. Shared Responsibility between the NHCPC and HHS will be as follows:

1. Two co-chairs will direct the NHCPC. The State Co-Chair will be appointed by HHS. The second, the Community Co-Chair, will be elected by the NHCPC membership. The terms of co-chairs are outlined in Article VI. of the Bylaws for the NHCPC.

2. Develop and implement policies and procedures that clearly address and outline systems for regularly re-examining:

    a. NHCPC composition, selection, appointment, and terms of office to ensure that it reflects, as much as possible, the population characteristics of the epidemic in State and local jurisdictions in terms of age, race/ethnicity, gender, sexual orientation, geographic distribution, and risk for HIV infection as well as persons living with HIV disease.
    b. Methods for reaching decisions, attendance at meetings, resolution of disputes identified in planning and decision making as well as resolution of conflict of interest(s) for members of the NHCPC.

    c. Roles and responsibilities of the NHCPC members and its various components (e.g. standing committees, ad hoc groups, or task forces).

3. Develop and apply criteria for selecting the individual members of the NHCPC with special emphasis being placed on procedures for identifying representatives of socioeconomically marginalized groups, persons at greatest risk for HIV transmission, and groups that are underserved by existing HIV prevention programs.

4. Provide a thorough orientation for all new members as soon as possible after election/appointment. New members should understand:

    a. The roles, responsibilities, and principles outlined in this document.

    b. The procedures and ground rules used in all deliberations and decision making.

    c. Specific policies and procedures for resolving disputes and avoiding conflict of interests that are consistent with the principles of the CDC Community Planning Guidance and Section VII of the Ryan White CARE Act Title II Manual.

5. Assess the present and future extent, distribution, and impact of HIV in defined populations.

6. Conduct a needs assessment process to identify unmet HIV prevention and care needs within defined populations.

7. Identify specific high priority prevention strategies and interventions for defined target populations.

8. Identify location, gaps, barriers, and effectiveness of services available to persons infected and living with HIV.

9. Integrate multiple sources of information, i.e., behavioral, treatment, psychosocial, geographic, scientific, cost effectiveness, etc., into a statewide, comprehensive HIV prevention and care plan.

10. Foster collaboration and coordination among agencies, individuals, and programming efforts relevant to HIV care and prevention including but not limited to: STD, TB, Substance Abuse and Prevention and Treatment, Women's Health Services, Mental Health Services, and other public health needs.

11. Evaluate the community prevention and care planning process to assure that it is meeting the core objectives for CDC Community Planning and HRSA Consortia Responsibilities.

B. Co-Chair responsibilities will be as follows:

1. Develop an agenda for each meeting based on input from the NHCPC members and HHS HIV staff.

2. Co-facilitate the meetings. If a meeting facilitator is used, assist said facilitator.

3. Participate in briefing prior to each meeting.

4. Participate in debriefings after each meeting.

5. Manage and resolve NHCPC conflicts.

6. Coordinate standing committee work and reports.

7. Represent the NHCPC to the public.

8. Advocate the work of the NHCPC.

9. Together with the NHCPC membership, lead the group in attaining the purpose of the group and its mission through active participation in process, solicitation of community input, supporting the principles of P.I.R., providing and/or seeking technical assistance from experts, and collecting/analyzing and disseminating relevant data as appropriate.

In addition to the time requirements outlined for the NHCPC meetings (estimate of four meetings per year from 8:00 a.m. to 5:00 p.m. and standing committee work), co-chairs can expect to spend an estimated additional 24 hours per quarter on NHCPC business.

C. NHCPC individual member responsibilities will be as follows:

1. Make a commitment to the mission of the NHCPC, its process, and results.

2. Participate in all decisions and problem solving in achieving the group's purpose.

3. Undertake special tasks as requested by the NHCPC.

4. Gather data and information as needed.

5. Serve as a representative spokesperson for the position served on the NHCPC.

6. Serve as a liaison between the NHCPC and the community/area represented by your position as well as the community at large.

7. Participate on a minimum of one standing committee for the NHCPC per calendar year.

8. Facilitate and/or serve as liaison with focus or special interest groups in order to ensure that information and input is obtained from targeted populations and communities.

9. Follow the Bylaws.

10. Support the Code of Conduct defined in this document (Section XIII).

11. Evaluate the process and assess the responsiveness and effectiveness of the HHS applications for federal HIV Prevention and CARE funds as identified in the Comprehensive HIV CARE and Prevention Plan.

12. Define technical assistance needs for the successful implementation of a comprehensive HIV prevention and care plan for Nebraska.

It is expected that NHCPC members will have to spend 16-24 hours per quarter on NHCPC related activities. This should include the time spent for travel, standing committee work, and other duties that may arise.

D. HHS HIV Program responsibilities will be as follows:

1. The HHS HIV Program is required to determine how best to achieve and integrate statewide, regional, and local community HIV planning within their jurisdictions. As such, the HHS HIV Program will establish and maintain the NHCPC, which meets the principles outlined in the CDC Community Planning Guidance and the HRSA Ryan White CARE Act Manual.

2. Identify a health and human service department employee, or a designated representative, to serve as Co-Chair for the NHCPC.

3. Each standing committee will have a State Liaison appointed by the HIV Program Administrator. The role of the liaison will be to facilitate the work of the committee and serve as a resource for materials, information, and direction.

4. Identify and assist in obtaining key leadership and expertise supporting the purpose and mission of the NHCPC including supporting P.I.R. principles within the process.

5. Ensure the NHCPC understands its roles and responsibilities.

6. Keep the NHCPC focused on the context within which the issues of HIV care and prevention take place: assessment, recommendation, evaluation, etc., not funding decisions.

7. Provide guidance and support to the community and state appointed co-chairs, standing committees, and members as necessary.

8. Provide technical assistance and support which may include but not limited to:

    a. Epidemiological information
    b. Descriptions of target populations
    c. Profiles of existing regional resources
    d. Information about strategies for HIV prevention
    e. Information about existing care and support services
    f. Support in conducting ongoing needs assessment
    g. Compile, collect, and analyze data as necessary
    h. Necessary information and materials to NHCPC
    i. Facilitate specific group activities
    j. Deal with logistics in setting up and facilitating meetings

9. Develop an application for HIV prevention cooperative agreement funds and Ryan White Title II funds per processes identified through the federal guidances provided by CDC and HRSA respectively. This includes seeking review of the HIV Prevention application as required and obtaining letters of concurrence/nonconcurrence from the NHCPC.

10. Provide periodic feedback to the NHCPC on the successes and barriers encountered implementing HIV prevention and care services statewide.

V. Standing Committees

The NHCPC will have five standing committees designated below. Committee members may be selected from the NHCPC membership and/or selected from the community at large. The committee chair must be a current member of the NHCPC and ensures the committee operates under the Bylaws and Operational Guidelines. Whenever possible members of committees should follow the principles of parity, inclusion, and representation as set forth in the Community Planning Guidance. The NHCPC chair(s) may create additional standing committees, ad hoc groups, or task forces as deemed appropriate to ensure that the mission of the NHCPC is successfully met.

A. CARE Services Committee

Purpose:

- Review the menu of Direct Client Services (limited to support services) and provide feedback to the Title II Program Manager regarding the adequacy of services.
- Provide recommendations to the Title II Program Manager regarding the addition or deletion of provided services.
- Research and provide information as necessary to identify additional services and assist in their procurement as necessary.
- This committee will not have authority for making client financial determinations or service limit.
- Assist in the development of additional resources for service provision.

B. Assessment and Evaluation Committee

Purpose:

- To review, identify strengths and weaknesses, and provide recommendations regarding prevention and care evaluation and assessment processes and results.

Duties:

- Review the comprehensive evaluation plan developed according to CDC and HRSA instructions and make recommendations for implementation.
- Review prevention and care assessment data and make recommendations as to services, gaps, barriers, and unmet needs.
- Review evaluation data and make recommendations as requested based on data type.
- Review the community planning process and survey data and make recommendations regarding the five core objectives.
- Recommend additional evaluation, assessment, and quality assurance activities based on pertinent data, trends and programmatic needs.

C. Interventions Committee

Purpose:

- To utilize statewide needs assessment information for the purpose of identifying, prioritizing, and recommending behavioral interventions for funding with HIV prevention funds. The effectiveness and support of the implementation of these recommended interventions should be based in behavior change theory, be cost effective, and compatible with the norms, values and relevance for the communities where they will be introduced.

Duties:

- Review recommended interventions from regional areas and target populations.
- Prioritize interventions based on social science theory, cost effectiveness, and acceptability of local norms and values.
- Work with HHS HIV program on viability of implementation of interventions being assessed.
- Recommend prioritized interventions for funding by HHS.

D. Membership Committee

Purpose:

- Recruit and orient persons committed to the prevention and care concerns of those at risk for or living with HIV disease. The Membership Committee will solicit new members under the guiding principles of achieving parity, inclusion, and representation of the epidemic for the NHCPC. Personal knowledge and expertise will be sought for positions, which contribute critical information to the development of a comprehensive HIV care and prevention plan.

Duties:

- Recruit candidates for Community Co-Chair and conduct Community Co-Chair elections.
- Recruit new members for position vacancies (new members should be identified and recommended for appointment to begin positions each January).
- Recommend new recruits for acceptance for NHCPC membership.
  - Advertisement for recruitment should be done statewide
  - Recruitment should follow PIR guidelines
  - Consideration should be given to achieve membership balance in the areas of geographic representation, race/ethnicity, age, gender, sexual identity, risk behavior, and ability to actively participate
- Assign new members to standing committees with input from the new member and the Committee Chairpersons.
- Fill positions that may be vacated prior to end of membership term.
- Orient new members to NHCPC purpose and goals.
- Ensure barriers for membership participation is minimized, (i.e. application forms in are multi-language, translation and/or other special needs addressed).
- Maintain and update member notebooks as necessary.

E. Public Information Committee

Purpose:

- To review proposed educational materials, to discuss media and education that is made available to communities, make recommendations for educational materials, and participate in the development of a public information plan.

Duties:

- Review educational materials including brochures, videos, etc. to ensure they meet CDC guidelines.
- Build a resource inventory of approved materials.
- Provide input and recommendations to the annual public information plan.
- Recommend new educational material for purchase.

F. Committee Chair Role

1. Call and facilitate a minimum of three committee meetings each calendar year.
2. In collaboration with State Liaison for the committee, set agenda for meeting and make arrangements.
3. Ensure minutes, sign-in sheets, and expense documents are utilized and forwarded to HHS.
4. Provide summary of meeting outcomes to NHCPC co-chairs and report to NHCPC membership as necessary.
5. Recruit non-NHCPC members as needed to fulfill the duties of the committee.
6. Request technical assistance as needed to fulfill the duties of the committee.

G. Committee Member Role

1. Participate in a minimum of three committee meetings each calendar year.
2, Actively participate in work of the committee to fulfill committee duties.
3. Assist in recruiting additional non-NHCPC members as needed to fulfill the duties of the committee.
4, Solicit information and perform activities as necessary to fulfill committee duties.
5. Ask for technical assistance as necessary to participate as an active member on committee and in committee activities.

VI. Orientation

Active participation from members on the NHCPC is critical for the work to be accomplished in a timely and efficient manner. The membership structure of the NHCPC is designed to bring new voices to the "table" on a rotating basis to allow for comprehensive involvement by the community. Because the number of meetings for the NHCPC and its standing committees will be limited, it is important that all members are prepared to fully participate at each meeting.

New members will be provided an orientation session prior to their attendance at their first meeting. The Membership Committee, in collaboration with the NHCPC Co-Chairs, will provide orientation sessions each year for new members joining the group. A verbal orientation along with a membership handbook/manual will be given to each new member. Retiring members or members terminating their position commitment should return their membership handbook during the last meeting they attend or make arrangements with the Chair of the Membership Committee to return the handbook.

Any individual member currently serving on the NHCPC or a co-chair may request update training or technical assistance if such training/assistance is felt to be needed to more fully participate or understand the group's process. The Membership Committee, with the assistance of the NHCPC Co-Chairs, will facilitate access to the requested training as appropriate and upon approval by the State HIV Program.

VII. Open Meeting Laws

The basic statement of Nebraska State policy on public meetings is found at Neb.Rev.Stat. §84-1408. This statute provides, "It is hereby declared to be the policy of this state that the formation of public policy is public business and may not be conducted in secret. Every meeting of a public body shall be open to the public in order that citizens may exercise their democratic privilege of attending and speaking at meetings of public bodies, except as otherwise provided by the Constitution of the State of Nebraska, federal statutes, and sections 79-327, 84-1408 to 84-1414, and 85-104."

Open meetings provisions apply to meetings of any "public body", which includes governing bodies of local and state governmental units; independent boards, commissions, councils, and other similar bodies; advisory groups to the executive branch and to public bodies, and instrumentalities exercising essentially public functions.

The NHCPC will follow the Open Meeting Laws for the State of Nebraska and follow the accepted guidelines and definitions outlined in the Handbook on Public Meetings. Brief highlights/fact statements about open meeting guidelines will be provided to each NHCPC member as a part of their orientation.

VIII. Expenses

Reimbursement of expenses for volunteer members of State affiliated boards, committees, commissions, and task forces may be provided per HHS DAS Administrative Policy, pursuant to Section 81-118L.01. State law prohibits the payment for services until the service has been provided which in turn requires the HIV program to reimburse a member's expenses *after* the NHCPC meetings occur. Mileage at the state reimbursement rate, meals at per diem rates, lodging and parking expenses may be reimbursed to individual members. The program cannot reimburse agencies or reimburse for the use of agency vehicles. If more than one NHCPC member shares transportation to a meeting, only reimbursement to the owner/driver of the vehicle used will be given.

The process and details for reimbursement of expenses will be covered in new member orientation and may be found in the member handbook, (example: lodging for members attending a meeting of the NHCPC will be reimbursed at the state approved rate when the member is traveling more than 60 miles one-way to the meeting).

Should a member require "special assistance" to attend meetings or standing committee functions on behalf of the NHCPC, a process is in place to assist members prior to their arrival at the meeting/function. Details and management of this process may be accessed through the State Co-Chair.

IX. Lobbying

The NHCPC operates under direct affiliation with Nebraska Health & Human Services HIV Program and its cooperative agreements with the Centers for Disease Control and Prevention and the Health Resources and Services Administration. Funding for support of this advisory group and its related functions are provided through these federal cooperative agreement funds. Therefore, the NHCPC, its activities, and the activities of its designated standing committees, ad hoc groups, or task forces must follow restrictions determined by federal guidelines.

Under the provisions of 31 U.S.C. Section 1352 (which has been in effect since December 23, 1989), recipients (and their subtier contractors) are prohibited from using appropriated Federal funds (other than profits from a Federal contract) for lobbying Congress or any Federal agency in connection with the award of a particular contract, grant, cooperative agreement, or loan. This includes grants/cooperative agreements that, in whole or in part, involve conferences for which Federal funds cannot be used directly or indirectly to encourage participant to lobby or to instruct participants on how to lobby.

In addition, no part of any appropriation may be used for publicity, propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to defeat legislation pending before the Congress or any State legislature. No part of any appropriation contained in Public Law 105-78 can be used to pay the salary or expenses of any grant, contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

X. Code Of Conduct

The following ground rules define appropriate group behavior standards. The standards provide guidance for member functions within the group and within their respective agencies and/or communities as representatives of the Nebraska HIV CARE and Prevention Consortium.

A. Commit to regular meeting attendance and active participation;

B. Act first and foremost as a member of the NHCPC and within the best interest of the group;

C. Put aside personal agendas;

D. Separate agency/organizational goals and needs from those of the NHCPC, standing committees, ad hoc groups, or task forces.

E. Share all pertinent feedback, both positive and negative, within the group;

F. Discuss/resolve concerns during meetings, not behind closed doors or outside the advisory group;

G. Be positive about the advisory group, its mission and purpose;

H. Exercise discretion to maintain the group's integrity (i.e., not airing "dirty laundry" in public);

I. Acknowledge and respect all variant views;

J. Respect each other's differences, knowledge, experience and frame of reference.;

K. All comments will be made in a respectful and reasonable timeframe; filibustering will not be considered respectful or reasonable as applicable to the purpose and mission of the NHCPC.

XI. Conflict of Interest

A conflict of interest can be defined as a conflict between one's obligation to the public good and one's self interest, whether that interest be a personal interest, or interest of family, friend or work related. A conflict of interest occurs when an appointed or elected individual knowingly takes action or makes a statement intended to influence the conduct/decisions of the public body of which he or she is a member. If the member's action in any way confers any financial or programmatic benefit to the member or the organization, persons, program, etc. the member is affiliated with, a conflict of interest is present.

The Nebraska HIV Care and Prevention Consortium, in their advisory relationship to the State's HIV Program, functions as a public body. The mission and purpose of the NHCPC are designed to address the HIV issues impacting all Nebraskans and thus work on behalf of the "public good". A NHCPC member who also serves as a director, trustee, salaried employee, volunteer, or otherwise benefiting from any HIV / AIDS prevention or CARE funds is deemed to have an "interest" in the decisions of the NHCPC and must declare their conflict openly and be excluded from voting on those decisions.

XII. Dispute Resolution

To develop an inclusive approach for addressing the HIV prevention and care needs of a particular community, a wide range of representatives and information must be involved in the planning processes. This variety and diversity of opinions, beliefs, values, and ways of communicating add the needed ingredients for developing a comprehensive plan for addressing both prevention and care needs. Despite careful organizational development, effectiveness of meetings and commitment of participants, disagreements and conflicts inevitably arise and may become disputes. Conflicts among NHCPC members may arise within meetings and outside of meetings, (i.e., ad-hoc meetings, special activities, committee meetings).

When conflicts arise in the process of making decisions at NHCPC meetings, an attempt will be made to work through the conflict and achieve consensus among members of the issue at hand. Consensus decision making is defined as a decision in which all members of the group support or can live with the decision in question.

Consensus decision making is not easy. This is especially true when the decision making body is comprised of individuals representing diverse points of view. Consensus decision making requires full discussion, individual and collective honesty, and sharing of all relevant information. In order for a consensus decision making process to be successful:

A. Each participant's view on the issue at hand needs to be shared with the group.

B. The interests of each participant must be identified. (An interest is the core or driving force that makes that issue important to that person. A participant's interest can usually be identified by asking, "Why is this issue important to you?".)

C. The interests of each participant need to be able to be understood by all of the participants. (This <u>does not</u> mean everyone must agree with the interests identified but it does mean that everyone understands what the interests of each participant are.)

D. Once the interests of the participants are understood, several options to resolve the issue at hand must be generated by the group.

E. Any option selected to resolve the issue must meet at least <u>some</u> of the interest of all participants.

In order to meet open meeting law requirements, any consensus decision will then be recorded in a roll call vote. In the event that the group, after identifying interests and generating options, cannot reach consensus, the NHCPC will resort to the use of a role call vote.

When conflicts arise outside of NHCPC meetings concerning NHCPC business, members are urged to use the same model as above in resolving the issue at hand.

XIII. Grievance – Statement of Concern Procedures

Grievances concerning decisions made or actions taken by NHCPC must be filed in writing with the HIV Program Administrator. The HIV Program Administrator will establish an oversight committee to deal with the filed grievance. The oversight committee will consist of:

- HIV Program Administrator
- State Co-Chair
- Community Co-Chair
- Two members of the NHCPC selected by the HIV Program Administrator and agreed upon by the Co-Chairs.

The oversight committee will review the filed grievance. The committee, upon reviewing the grievance, may:

A. Request a meeting with the individual who has filed the grievance if the committee feels such a meeting would be helpful in understanding the grievance.

B. Request that the party filing the grievance mediate with representatives of the oversight committee as appointed by the HIV Program Administrator. The mediator in such a situation would be a neutral third party who has no vested interest in the outcome of the mediation. If the mediation is successful (agreement is reached between the parties), a part of the mediated agreement would be the withdrawal of the grievance by the party who filed the grievance.

C. Investigate the grievance, respecting the confidentiality of all concerned parties, and present recommendations to NHCPC as to an appropriate disposition of the matter. Once a decision is made by NHCPC, a written response to the individual who filed the grievance will be made within 30 days. The committee, in its written response, will either uphold the original decision by NHCPC or will request that NHCPC re-examine the issue raised in the grievance and take new action of the issue raised in the grievance.

Grievances concerning the performance or conduct of an individual NHCPC member (either a standing member or elected member) must be filed in writing with the HIV Program Administrator. The HIV Program Administrator will establish an oversight committee to deal with the filed grievance. The oversight committee will consist of:

- HIV Program Administrator
- State Co-Chair
- Community Co-Chair
- Two members of the NHCPC selected by the HIV Program Administrator and agreed upon by the Co-Chairs.

The oversight committee will review the filed grievance. The committee, upon reviewing the grievance, may:

A. Request a meeting with the individual who has filed the grievance if the committee feels such a meeting would be helpful in understanding the grievance.

B. Request that the party filing the grievance mediate with the individual who they have filed the grievance about. The mediator in such a situation would be a neutral third party who has no vested interested in the outcome of the mediation. If the mediation is successful (agreement is reached between the parties) a part of the mediated agreement would be the withdrawal of the grievance by the party who filed the grievance.

C. Investigate the grievance, respecting the confidentiality of all concerned parties, and present recommendations to NHCPC as to an appropriate disposition of the matter. Options for consideration by NHCPC include:

1. A motion may be made to vote to remove the individual from NHCPC pursuant to ARTICLE IV., Section 3 of the Bylaws.

2. A motion may be made to call the question and the topic is tabled.

3. A motion may be made and a vote taken to take no further action on the grievance filed. Once a decision is made by NHCPC, a written response to the individual who filed the grievance will be sent within 30 days.

Changes Approved: 3/26/2002
Changes Approved: 1/23/2003
Changes Approved: 2/14/2004
Changes Approved: 4/22/2004
Changes Approved: 6/24/2004
Changes Approved: 8/19/2004

ATTACHMENT No.3

NHCPC 2004 MEMBER PROFILE

Region of Residence	
Western	3
Northern	1
Central	3
Eastern	9
Southwest	0
Southeast	5
Not reported	2

Geographic Location	
Rural	5
Urban Metropolitan	14
Urban Non-Metropolitan	2
Not reported	2

Age	
19 and under	0
20-29	3
30-39	5
40-49	8
50-59	5
60 and older	2
Not reported	0

Gender	
Female	13
Male	10
Transgender	0
Not reported	0

Sexual Orientation	
Bisexual	0
Gay Man	5
Heterosexual	18
Lesbian	1

Ethnicity	
Hispanic or Latino	1
Non-Hispanic or Non-Latino	15
Unknown	0
Not reported	7

Race	
Asian	1
Black/African American	5
Native American/Native Alaskan	0
Caucasian	15
Native Hawaiian/Pacific Islander	1
Multiple Race	1
Other	0
Not reported	1

Risk Factors	
IDU	1
MSM	5
Mother with or at risk for HIV	0
High risk heterosexual practice	1
MSM/IDU	0
No identified risk	11
Other	2
Not reported	3

Expertise	
Epidemiologist	1
Health planner	4
Behavioral/Social scientist	2
Community representative	10
Evaluation/Researcher	1
Intervention specialist	5
Other	4
Unknown	3
Not reported	0

Agency Affiliation	
Academic institution	0
Local/City/County health dept	4
Other Governmental	3
State health department	1
Faith	1
Minority board	0
Non-Minority board	0
Other non-profit	12
Individual	3
Research center	0
Other	4

Living with HIV	
Yes	4
No	17
Unknown	2
Not reported	1

Affected by HIV	
Yes	7
No	11
Unknown	1
Not reported	4

ATTACHMENT No. 4

NHCPC ORGANIZATIONAL CHART

Nebraska HIV CARE and Prevention Consortium

EX-OFFICIO

State HIV Program Administrator

APPOINTED

State Co-Chair

State Title II Coordinator

Title III Coordinator
Title III Coordinator

Direct Provider for STDs

Division of Adolescent and School Health (Nebraska Dept of Education)

Medicaid Issues

Behavioral Health

Behavioral Health

Epidemiologist

State Corrections

AIDS Drug Assistance Program

ELECTED

CTR-PCRS (Counseling &Testing)

Prevention Subgrantee

City/County Health Dept

HIV Case Management

Mental Health/ Substance Abuse

Minority CBO

Minority HIV Impacted

ELECTED

MSM - Urban (+ or -)

MSM - Rural (+ or -)

MSM - of Color

Woman at Risk HIV Infected or Affected

Injecting Drug User

Red Ribbon Community

Person Living with HIV or AIDS

Person Living with HIVor AIDS

REGIONALLY ELECTED

Western Region

Southwest Region

Central Region

Northern Region

Eastern Region

Southeast Region

ATTACHMENT No. 5

2004 MEMBERSHIP APPLICATION

Letter of Interest to Participate/Application for Membership

Note: The information contained in this application is considered confidential and will not be available to the public. The information will be used for the purpose of fulfilling consortium requirements outlined through Nebraska Health & Human Services Cooperative Agreements with the Centers for Disease Control & Prevention and the Health Resources Services Administration.

The information below indicates my desire and willingness to be selected as a member in the Nebraska HIV CARE & Prevention Consortium (NHCPC).

Name:_____ **Day Phone:**_____
Address:_____ **Home Phone:**_____
City:_____ **Zip:**_____ **Fax:**_____
Employer:_____ **E-mail:**_____

The above mailing address is my **_____Home** **_____Office**

Ethnicity		***Age***	***Gender***
____White (non-Hispanic)	____Native American	____10 to 19	
____African American	____Middle Eastern	____20 to 29	____Male
____Hispanic/Latino	____Other	____30 to 39	____Female
____Asian/Pacific Islander		____40 to 49	____Transgender
		____50 or above	

Group Representation Position Applying For

(No more than two. Please note 1st and 2nd choices)

1____CTRPN - HHS funded (Counseling/Testing)
2____Prevention Subgrantee - HHS funded
3____HIV Case Management - HHS funded
4____Minority Community Based Organization (CBO)
5____Minority – HIV Impacted
6____City/County/District Health Department
7____MSM – Rural (outside Lincoln/Omaha areas)
8____MSM – Urban (Lincoln/Omaha areas)
9____MSM – Person of color
10____ Woman – HIV Impacted
11____Intravenous Drug User (IDU)
12____ Person Living with HIV
13____Mental Health/Substance Abuse

I have been involved with HIV/AIDS issues in the following areas:

_____
_____
_____

I am qualified to represent these positions because:

Choice #1:_____

_____
_____

*Choice #2:*_____

_____
_____

(Please continue on the back)

I am interested in becoming a member of the NHCPC because:

_____

_____

_____

_____

I am able to participate/commit up to 15 hours per quarter and travel to meetings in Lincoln for the NHCPC.	**I am willing to serve a three (3) year term with the NHCPC.**
_____YES _____NO	**_____YES _____NO**

Disclosure of Conflict of Interest:

Persons who may become members of the Nebraska HIV CARE and Prevention Consortium (NHCPC) may be affiliated with organizations that have or may request funds for HIV prevention and/or care activities. Because of this potential for conflict of interest, this disclosure information is being requested.

I and/or a family member currently is or has been within the past 12 months a staff member, consultant, officer, board member, or in an advisory capacity with the following organizations:

1) **Organization:_____**
   Title:_____Period of Affiliation_____

2) **Organization:_____**
   Title:_____Period of Affiliation_____

Signature:_____Date:_____

PLEASE MAIL TO:

Christine Stroud
HHS – HIV Prevention Program
PO Box 95044
Lincoln, NE 68509-5044

ATTACHMENT No. 6

2004 ORIENTATION GUIDE

Individually we are special,

Together we are spectacular

Nebraska HIV

CARE & Prevention

Consortium

(NHCPC)

Orientation Guide

NHCPC Orientation Checklist

Date	Initials	
_____	_____	I have received and read the orientation manual.
_____	_____	I have participated in an orientation program.
_____	_____	I have completed a Membership Skills Inventory.
_____	_____	I have read, understood, and signed a Disclosure of Conflict of Interest Statement.
_____	_____	I have been introduced to the Community and State Co-chairs for the NHCPC.
_____	_____	I have been assigned to a standing committee and have met the standing committee chairperson.
_____	_____	I know how to fill out an Expense Reimbursement form.
_____	_____	I have received an evaluation form for orientation, have completed it, and have returned it.

_____

NHCPC New Member Date _____

_____

Membership Committee Date _____

INDEX

NHCPC Community Co-Chair

_____

NHCPC State Co-Chair

_____

My Standing Committee Members

_____

_____

_____

_____

_____

_____

WELCOME

Thank you for agreeing to join us as we strive to reduce the number of new cases of HIV within our State and to improve the quality of life for those who are HIV+.

The mission of the Nebraska HIV Care and Prevention Consortium (NHCPC) is to develop a comprehensive HIV Care and Prevention Plan for the State of Nebraska. By identifying strategies and interventions that are responsive to needs within the defined populations, we hope to achieve these goals.

During your time as a NHCPC member you will receive support from the co-chairs and other members. This booklet is designed to assist you with your orientation and to answer basic questions about the NHCPC.

We look forward to working in partnership with you!

OUR HISTORY

The Centers for Disease Control and Prevention (CDC) first mandated community planning for HIV prevention in 1993. The commitment of the CDC to strengthen community-specific HIV prevention interventions was behind the development of the NHCPC.

The NHCPC is a merger between the HIV Prevention Community Planning initiative of the CDC and the Health Resources and Services Administration (HRSA) Ryan White Consortia. The CDC funds HIV prevention activities, while the Ryan White CARE Act provides funding for direct care services for HIV+ individuals. The union of these organizations provides focused decision making essential to comprehensive planning.

MISSION

The mission of the NHCPC is to develop a Comprehensive HIV CARE and Prevention Plan for the State of Nebraska by identifying specific strategies and interventions that are responsive to validated needs within defined target populations affected by HIV.

RESPONSIBILITIES OF THE NHCPC

- Assessing the extent of the HIV epidemic
- Assessing the existing prevention resources
- Identifying unmet HIV prevention and care needs
- Defining the potential impact of specific prevention strategies
- Prioritizing HIV prevention and care needs, developing a locally specific prevention and care plan, and evaluating the planning process
- Reviewing and endorsing a Statewide Coordinated Statement of Need
- Reviewing the Prevention Application to the CDC and giving concurrence or non-concurrence

FIVE CORE OBJECTIVES

1. Foster openness and participation in the community planning process.
2. Ensure that the target communities reflects the diversity of the epidemic and that expertise in epidemiology, social/behavioral science, health planning, and evaluation is included in the planning process.
3. Ensure that priority HIV populations are determined based on epidemiological data and needs assessments.
4. Ensure that interventions are based on explicit consideration of priority needs, outcome effectiveness, cost and cost effectiveness, theory, and community norms and values.
5. Foster strong, logical links between the community planning process, the application for funding, and the allocation of CDC HIV prevention resources.

MEMBERSHIP COMPOSITION

1. Must be geographically balanced and reflect the diversity of the HIV epidemic. Recruitment of members if guided by the principles of parity, inclusion, and representation, as established by the CDC.

2. Maximum number of members will be 38.

    a. Standing members are appointed by the HIV Program Administrator and are designated per requirements of the CDC and HRSA. They represent related state agencies and others recommended to serve in order to balance CDC requirements. Standing members comprise no more than 1/3 of the total membership.

    b. Elected members will represent related functional areas, persons directly impacted by the epidemic, and geographic representation. These members comprise no more than 2/3 of the total membership.

3. A member may resign at any time by submitting a written letter of resignation to either the Community or State Co-Chair.

4. Any member in violation of the Code of Conduct may be removed by majority vote (see Operational Guidelines).

MEMBER JOB DESCRIPTION

Role:
As a member of the Nebraska HIV CARE and Prevention Consortium (NHCPC) it is your role to:

- Make a commitment to this process and its results.
- Participate in all decisions and problem solving.
- Undertake special tasks, as requested by the NHCPC.
- Gather data and information as needed.
- Spread the word about the planning process.
- Serve on at least one standing committee.

Length of Commitment:
NHCPC elected members serve for a term of three years. Members may not serve for more than two consecutive terms. Standing members serve at the discretion of the HIV Program Administrator.

Estimated Time Required:
- Four meetings per year, which normally are scheduled for eight hours. One meeting per year may be two days long.
- Rare homework assignments.
- Committee Chair may require additional hours of commitment.

Expenses:
Travel expenses, including mileage, lodging, and meals, are reimbursed by the State. You will be asked to fill out an Expense Reimbursement Document for each meeting.

Attendance Policy:
A member who has three absences within a calendar year, whether excused or unexcused, will be considered non-participating and be replaced. A member who has two unexcused absences within a calendar year will be considered non-participating and be replaced.

CODE OF CONDUCT

- Commit to regular meeting attendance and participation.
- Actions/comments should be in the best interest of the group.
- Put aside personal agendas.
- Separate agency goals and need from needs/business of the Consortium.
- Share all feedback, positive and negative, within the NHCPC.
- Discuss/resolve concerns during meetings.
- Be **Positive** about NHCPC, its mission, and purpose.
- Acknowledge and respect the views, differences, knowledge, experiences, and frames of reference of everyone.
- Comments should be made in a respectful manner and in a reasonable timeframe.

CONFLICT OF INTEREST

All NHCPC members sign a Conflict of Interest form annually. This form lists organizations with whom they are affiliated. This helps to maintain the reputation and credibility of the NHCPC in making fair, objective, and impartial decisions.

MEETINGS

- The NHCPC shall hold four formal meetings per calendar year.
- The meeting agenda will be mailed to members at least 10 days prior to next scheduled meeting.
- All meetings are open to the public.
- Minutes will be taken and available 10 days following the meeting.
- Decisions will be made by consensus whenever possible. Should consensus not be achieved, voting procedures shall follow the guidelines set forth in Robert's Rules of Order.
- All formal decisions are documented through roll call vote.
- A quorum is 60% of the current NHCPC membership.
- Voting procedures follow Robert's Rules of Order.
- Written notice of time and location of all NHCPC meetings must be posted 24 hours prior to the meeting.
- Co-chairs may call special meetings with 10 days advance notice.

DIRECT CARE & PREVENTION PLANNING RESPONSIBILITIES

The NHCPC has advisory responsibilities for both the **Direct CARE Services** and the **Prevention** HIV Programs in Nebraska. Direct services to HIV+ individuals are offered primarily through the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act and funded by the Health Resources and Services Administration (HRSA). Prevention community planning is funded primarily by the Centers for Disease Control and Prevention (CDC). The following are brief descriptions of the two primary components of the HIV Program in Nebraska:

A. RYAN WHITE PROGRAMS

The Ryan White CARE Act is a federally funded program which provides direct care and support services to persons living with HIV/AIDS. In Nebraska, the Ryan White Program consists of Title II and Title III Services. The NHCPC serves as an advisory body to the Ryan White Title II Services only. Title III Services are provided by non-profit organizations.

Title II Services include:

- Home and community-based health care and support services, such as transportation and rent/utility assistance
- Case management
- Health Insurance Continuum of Coverage (HICC) program
- AIDS Drug Assistance Program (ADAP), which provides pharmaceutical treatment to persons with HIV/AIDS

Title III Services include:

- Primary medical care
- HIV Counseling, Testing, and Referral (CTR)
- Specialized care, such as dermatology or optometry
- Outpatient mental health services
- Outpatient substance abuse services
- Oral health care
    - Nutritional care

Title III is a payor of last resort. Currently, there are three Title III programs in Nebraska:

- University of Nebraska Medical Center (UNMC) Early Intervention Services (EIS) program
- Western Community Health Resources (WCHR) EIS program
- Charles Drew Health Center Title III Planning Grant

B. HIV PREVENTIONCOMMUNITY PLANNING

HIV Prevention Community Planning is a collaborative process through which State Health Departments work in partnership with community planning groups, such as the NHCPC, to design local prevention plans that best represent the needs of the various communities at risk for, or infected with, HIV. Prevention activities are funded by the Center for Disease Control (CDC).

A comprehensive HIV Prevention Program includes:

- HIV prevention community planning process
- Epidemiologic and behavioral surveillance profile
- HIV counseling, testing, referral and partner counseling and referral services (CTR/PCRS)
- Health education and risk reduction (HE/RR) activities
- Easy access to diagnostic and treatment of STDs
- School-based education efforts for youth
- Public information programs
- Quality assurance and training
- Evaluation of program activities
- Technical assistance plan
- Capacity building
- Laboratory support

STANDING COMMITTEES

The NHCPC has established five standing committees.

1. Membership
2. Evaluation and Assessment
3. Interventions
4. CARE Services
5. Public Information

- The majority of work activity and outcomes will be done in these standing committees.
- Each member of the NHCPC must serve on at least one standing committee.
- Standing committee members may be recruited from outside of the group (non-NHCPC members).
- The standing committee chair must be an NHCPC member.
- All standing committee members must abide by the NHCPC Bylaws and Operational Guidelines.

A. Membership

Parity, Inclusion, and Representation (P.I.R.) are fundamental goals in community planning. The Membership Committee is responsible for maintaining these goals.

- Recruit new member applicants committed to the prevention and care of those at risk or living with HIV.
- Recommend new recruits for membership acceptance.
- Orient new members to purpose and goals of the NHCPC.
- Recruit new members for standing committee vacancies.
- Fill vacancies which occur prior to end of membership term.

State Liaison: _____

Chairperson: _____

B. EVALUATION AND ASSESSMENT

Reviews the prevention and care evaluations and assessments, identifies strengths and weaknesses, and provides recommendations.

- Review the comprehensive evaluation plan developed in accordance with CDC & HRSA instructions and make recommendations for implementation.
- Review prevention and care assessment data and make recommendations about service, gaps, barriers, and unmet needs.
- Review evaluation data and make recommendations (data type).
- Review the community planning process and survey data and make recommendations regarding the five core objectives.

State Liaison: _____

Chairperson: _____

C. INTERVENTIONS

Utilizes statewide needs assessment information for the purpose of identifying, prioritizing, and recommending behavioral interventions for HIV prevention funding. Effectiveness and support for these interventions should be based on behavioral change theory, be cost effective, and be compatible with the norms, values, and relevance of the communities where they will be introduced.

- Review recommended interventions from regional areas.
- Prioritize interventions.
- Work with the HHS HIV Program on viability of implementation.
- Recommend interventions to HHS for funding.

State Liaison: _____

Chairperson: _____

D. CARE SERVICES

- Review menu of Direct Client Services (limited to support services) and provide feedback to the Title II Program Manager regarding the adequacy of services.
- Provide recommendations to the Title II Program Manager regarding the addition/deletion of provided services.
- Research and provide information identifying additional services and assist in their procurement as necessary.
- Assist in the development of additional resources for service provision.
- Committee **will not** have authority to make client financial determinations or service limits.

State Liaison: _____

Chairperson: _____

E. PUBLIC INFORMATION

Reviews educational materials to meet CDC guidelines pertaining to program materials review panel.

- Review public information campaigns.
- Review resources for public information.
- Develop resource information database.
- Review video and other audiovisual materials.

State Liaison: _____

Chairperson: _____

ACRONYMS

ADAP *AIDS Drug Assistance Program*: A program authorized and primarily funded under Title II of the Ryan White CARE Act; administered by State agencies for providing FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.

AIDS *Acquired Immunodeficiency Syndrome*: Disease caused by the human immunodeficiency virus (HIV).

CARE *Comprehensive AIDS Resources Emergency Act*: The Federal legislation (Ryan White CARE Act) created to address the health care and service needs of people living with HIV disease and their families.

CBA *Capacity building assistance*

CBO *Community-Based Organization*: An organization which provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.

CDC *Centers for Disease Control and Prevention*: The Federal agency within the U.S. Department of Health and Human Services that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process.

CD4 One of the two protein structures on the surface of a human cell that allows HIV to attach, enter, and thus infect a cell. The CD4 cell count is the most commonly used surrogate marker for assessing the state of the immune system. The normal range for CD4 cell counts is 500 to 1500 per cubic centimeter of blood.

CTR/PCR *Counseling, Testing, Referral and Partner Counseling and Referral Services*

DHAP *Division of HIV/AIDS Prevention (see CDC)*

ELISA *Enzyme-Linked Immunosorbent Agency*: The most common test used to detect the presence of HIV antibodies in the blood, which are indicative of ongoing HIV infection.

EPI Epidemiological profile

GLBTQ *Gay, lesbian, bisexual, transgender, questioning*

HCV *Hepatitis C virus*

HC/PI *Health communication/public information*

HERR *Health Education and Risk Reduction*

HHS *Health and Human Services*

HICCP *Health Insurance Continuum of Coverage Program*: A program authorized and primarily funded under Title II of the CARE Act that makes payments on behalf of a client to maintain his or her health insurance coverage.

HIV *Human Immunodeficiency Virus*: The virus that causes AIDS.

HOPWA *Housing Opportunities for People with AIDS*: A program administered by the US Department of Housing and Urban Development which provides funding to support housing for PLWA's and their families.

HRSA *Health Resources and Services Administration*: The agency of the US Department of Health and Human Services that is responsible for administering the CARE Act.

IDU *Injection Drug User*

MSM *Men who have Sex with Men*

NAP *Nebraska AIDS Project*

PEMS *Program Evaluation Monitoring System*

P.I.R. *Parity, Inclusion, Representation*

PLWA *Person Living with AIDS or HIV*

PMS *Post Marketing Surveillance*: A study that documents the effectiveness of HIV rapid testing

RARE *Rapid assessment, response, and evaluation model*

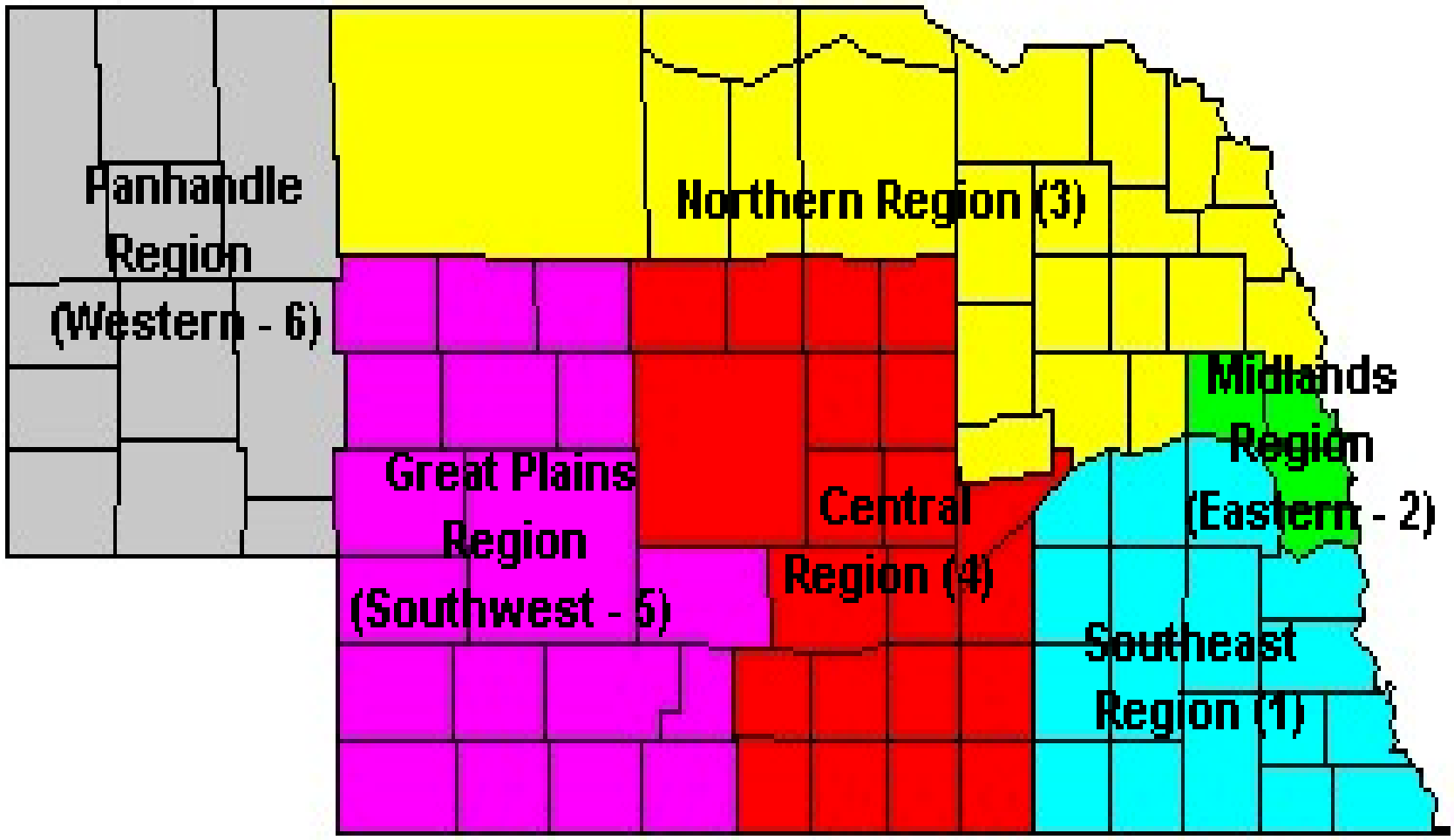
SCSN *Statewide Coordinated Statement of Need*: A written statement of need for the entire State developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act program coordination.

STD *Sexually Transmitted Disease*

TA *Technical Assistance*

UNMC *University of Nebraska Medical Center*

ORIENTATION NOTES


Panhandle Region (Western - 6)
Northern Region (3)
Midlands Region (Eastern - 2)
Great Plains Region (Southwest - 5)
Central Region (4)
Southeast Region (1)

July 2004

ATTACHMENT No. 7

2004 CONFIDENTIALITY AND CONFLICT OF INTEREST FORM

NEBRASKA HIV CARE AND PREVENTION CONSORTIUM

Guidelines Regarding Confidentiality and Conflict of Interest

You have been selected to partner with the Nebraska Health and Human Services HIV Program (NHHS) as a member of the Nebraska HIV CARE and Prevention Consortium (NHCPC). Guidelines for membership on this advisory body have been established by the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). These guidelines will be discussed as a part of the your orientation process. We appreciate the time you are taking to assist in this process and request that you read the following statement on Confidentiality and Conflict of Interest. You will be asked to update a disclosure of your potential conflicts of interest each year. Please sign the acknowledgement and agreement statement at the bottom of this page.

Confidentiality

Meetings of the NHCPC adhere to Nebraska statutes, policies and procedures concerning Open Meetings. However, disclosures or discussions which place a member at possible risk of harm to person or reputation shall be kept confidential and restricted to the business of the NHCPC and its' members. Information discussed and provided, whether written or oral, is for the purpose of accomplishing the missions and objectives of the advisory group. Members may share as much personal information as they feel comfortable with in the course of the NHCPC process but should be fully cognizant of the parameters of the Nebraska Open Meeting Laws. Members should be aware that staff of NHHS adhere to confidentiality principles but accept no responsibility for disclosures or actions by members that violate these principles. Confidentiality principles follow guidelines established by CDC and HRSA. Additional comments or questions should be referred to Sandra Klocke, Program Administrator for the HIV Program.

Conflict of Interest

Any member or subcommittee member of the Nebraska HIV CARE and Prevention Consortium who has a direct relationship with or to any agency, service organization, club, board, place of business, faith institution, or individual that may benefit from the actions of the NHCPC must disclose the relationship should be disclosed. The member(s) in conflict will be excused from the discussion and associated vote or action to eliminate the conflict of interest. A member's conflict of interest extends to relationships by the member and/or any direct connection by the member's family, partner, co-worker, business associate, fellow board members, etc. Written disclosure of potential conflict of interest will be updated each year, however if a relationship changes within the year, the member should update their written statement.

I have read, understand and agree to abide by the statements on Confidentiality and Conflict of Interest:

Name: _____ Date: _____

Signature: _____

Nebraska Health & Human Services
Nebraska HIV CARE and Prevention Consortium

Disclosure of Conflict of Interest

I, _____ and/or a family member and/or partner have been in a direct relationship with the following governmental, non-governmental, public or private organizations, board, service group(s) within the past 12 months and am disclosing a possible conflict of interest.

Organization: _____

Title/Relationship: _____ Period of Affiliation: _____

Organization: _____

Title/Relationship: _____ Period of Affiliation: _____

_____

Statement of Receipt and Acceptance of By-Laws and Operational Guidelines

I, as a member of the Nebraska HIV CARE and Prevention Consortium have received, read and agree to follow the By-Laws of said advisory group.

Printed Name: _____ Date: _____

Signature: _____

I, as a member of the Nebraska HIV CARE and Prevention Consortium have received, read and agreed to follow the Operational Guidelines for said advisory group.

Printed Name: _____ Date: _____

Signature: _____

ATTACHMENT No. 8

PRIORITY POPULATION WEIGHT/RANK SCORE SHEET

Priority Population Weight/Rank Score Sheet

Population

+

FACTOR	RATING INFORMATON	RANK/SCALE	WEIGHT	RANK SCORE	FINAL SCORE
					(Weight x Rank)
Predominant Mode/Risk Factor	What is the primary risk behavior known to occur among the target population?	1: None, unknown, or low risk 2: Unprotected Oral sex 3: Unprotected vaginal sex 4: Unprotected anal Sex 5: Blood to blood	5		
AIDS Prevalence	How many people in the target population are living with AIDS?	1: 0-25 2: 26-50 3: 51-75 4: 76-100 5: > 100	3		
HIV Prevalence	What is the estimated number of people living with HIV in the target population?	1: 0-25 2: 26-50 3: 51-75 4: 76-100 5: >100	3		
Barrier to Reaching the population/difficulty meeting population needs.	Are there significant barriers to reaching the target population with HIV prevention interventions..	1: Few or virtually no barriers 3: Moderate barriers 5: Substantial Barriers	1	Access: Language: Isolation: Provider: Testing access: Total score: _____	
Emerging Trends	Average HIV Incidence over 5 years.	1: 0-2 2: 3-5 3: 6-9 4: 10-12 5: > 12	4		

Total Score:

Access: A set of cultural, behavioral societal norms that may preclude the targeted population from allowing prevention outreach to permeate.
Language: (Barrier) Occurs when the primary language is one other than English.
Isolation: Geographic distance between members of the targeted population and prevention service providers.
Providers: Availability of prevention providers for the targeted population.
Testing: The availability of testing and/or test sites acceptable to the target population.

ATTACHMENT No. 9

RACE/ETHNICITY AND AGE FACTORS
RISK FACTORS

Race/Ethnicity and Age Factors
Risk Factors
Nebraska Priority Setting Process 2004
For 2005-2008

Ethnicity/Race	HIV	AIDS	Rank/Scale	Weight	Score: Rank x Weight			Final Score
	Rate*	Rate*			HIV	AIDS	Risk Factors	HIV + AIDS + Risk Factors
			Ranking Scale for HIV/AIDS Rates **1: 0 – 50** **2: 51-100** **3: 101-150** **4: 150-200** **5: 200+**	**3**				
White <19 years								
20-29 years								
30-39 years								
40-49 years								
50+ years								
African/American < 19 years								
20-29 years								
30-39 years								
40-49 years								
50 + years								
Hispanic < 19 years			**Ranking** ***Scale for Other Risk Factors*** ***1: 0 factors*** ***2: 1 factor*** ***3: 2 factors*** ***4: 3 factors*** ***5: all 4 factors***	***2***				
20-29 years								
30-39 years								
40-49 years								
50 + years								
American Indian/AN <19 years			Risk Factors *High STD rates *High use of C & T *Drug & ETOH abuse *Multiple partners					
20-29 years								
30-39 years								
40-49 years								
50 + years								
Asian < 19 years								
20-29 years								
30-39 years								
40-49 years								
50 + years								

Steps:
1. Determine rank for HIV and multiply by weight to calculate score for each age group in each race/ethnicity category. Enter score in appropriate box.
2. Repeat for AIDS data and enter in appropriate box.
3. Repeat for risk factors. If there is no clear age breakdown appropriate, score the race/ethnicity group.
4. Add the three scores: HIV, AIDS, Risk factors for the total score.
5.Circle the top six scores and transfer to Priority Population group sheet.

(* Based on occurrence per 100,000 population)

ATTACHMENT No. 10

POPULATION SUMMARY SHEET

Population Summary Sheet

❒ MSM ❒ MSM/IDU ❒ Male IDU ❒ Female IDU ❒ Male HRH ❒ Female HRH
(check one population for this summary sheet)

Age/Ethnicity/Race Group	Score
1._____	☐
2._____	☐
3. _____	☐
4._____	☐
5._____	☐
6._____	☐

YOU ARE DONE. Scores will be transferred to the final summary sheet by your staff facilitator!

ATTACHMENT No. 11

FINAL SCORE SUMMARY SHEET

Final Score Summary Sheet

Nebraska Priority Setting Process 2004
For 2005-2008

	MSM	MSM IDU	MALE IDU	FEMALE IDU	MALE HRHetero	FEMALE HRHetero
Weight/Rank Score						
Factors →→→	Score	Score	Score	Score	Score	Score
White <19 years						
20-29 years						
30-39 years						
40-49 years						
50+ years						
African/American < 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
Hispanic < 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
American Indian/AN <19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
Asian < 19 years						
20-29 years						
30-39 years						
40-49 years						
50 + years						
TOTALS						

Transfer the top six scores from each Population Summary Sheet to this sheet into the corresponding cell.
For tie scores that would include more than six scores, enter into appropriate cells.
Total the top *six scores only* plus the weight/rank score for each column.

ATTACHMENT No. 12

INTERVENTION COMMITTEE WORKSHEETS

Part One

Population-Specific Needs Assessment

For each assigned priority population, research and record findings on the following issues:

Specific Population _____

1) **What are the *daily realities* of the specific population? What is life like for them?**

2) **What are the *specific current prevention needs* of this population?** (condom negotiation skill-building, basic facts/knowledge, substance abuse, etc.)

3) What *specific barriers* is this population facing? (lack of transportation, abuse, access to care, etc.)

Part Two

Assigning the Weight for Intervention Criteria

When selecting priority interventions, CDC has directed us to consider several factors. These factors are listed in the chart below. Not all factors carry the same level of importance and so they need to be weighed based on local standards. As a group, decide the importance (or weight) for each of the following criteria. Note: Some criteria may carry the same weight as other criteria.

Criteria	Assign a weight for each of the following criteria **5** (MOST important) to **1** (LESS important)				
	5	**4**	**3**	**2**	**1**
High Priority Need – *The intervention addresses a high priority need given epidemiologic data, needs assessment data, and other relevant data.*					
Efficacy and Effectiveness – *The intervention is based on and supported by behavioral and/or social science theory. There are indicators that the intervention is effective or might be effective in averting or reducing high-risk behaviors or the population.*					
Practical – *The intervention is practical and workable given the availability of resources, expertise, funding, and the capacity to implement. The intervention can be sustained over time.*					
Appropriate – *The methods of delivery and curriculum content are appropriate for the population being targeted. The intervention is offered in the language of the target population and is culturally appropriate.*					
Can be Evaluated – *The intervention has a measurable outcome. The extent to which an intervention can demonstrate effectiveness (i.e. changes in behavior attitude, knowledge, beliefs) in the target population.*					
Addresses other Contributing Issues – *The intervention components address other areas that may contribute to increased risk of HIV transmission (e.g. substance use recovery, mental health, .etc.)*					

Part Three

Intervention Score Sheet

Use this form to arrive at the total score for each intervention.
Step 1. Transfer the assigned weights for each criteria (from Part Two).
Step 2. Score interventions on each criteria. Use the scale at the bottom of the page to determine scores.
Step 3. Multiply the WEIGHT times the SCORE you give the intervention for each criteria.
Step 4. Add these to get the TOTAL SCORE for each intervention.

Criteria ►	***High Priority***	***Efficacy & Effectiveness***	***Practical***	***Appropriate***	***Can be Evaluated***	***Contributing Issues***	*TOTAL SCORE*
Assigned Weight ► ***(transfer this number from Part Two worksheet AND then multiply it times the score you give each intervention for that criteria)***							
Interventions ***(list each intervention being considered)*** ▼							

SCALE: ***Score each intervention based on the following three choices;***

1 = No, the intervention does not adequately meet the definition for this criteria

2 = The intervention somewhat meets the definition for this criteria, but there is room for improvement

3 = Yes, the intervention meets the definition for this criteria

ATTACHMENT No. 13

2004 Resource Directory Survey

2004 RESOURCE DIRECTORY SURVEY

Please tab through the fields to enter your answers.

1. Your contact information:

Agency Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Email: _____

Website: _____

Type of company/agency/institution:

- ☐ Local health department
- ☐ Community health organization
- ☐ State health department
- ☐ Health care facility
- ☐ Private company/Corporation
- ☐ Consultant
- ☐ Community based organization
- ☐ Other - please specify:_____

2. Do you provide any education and/or services for:

- ◆ HIV/AIDS ☐ Yes ☐ No
- ◆ Ryan White ☐ Yes ☐ No
- ◆ STDs ☐ Yes ☐ No
- ◆ Hepatitis ☐ Yes ☐ No

3. What type of education and/or services do you provide? Mark all that apply.

- ☐ Individual education
- ☐ Counseling
- ☐ Group education
- ☐ Testing
- ☐ Skills building
- ☐ Case management
- ☐ Drug and alcohol treatment
- ☐ Mental health services
- ☐ Support Group
- ☐ Advocacy
- ☐ Medical/Dental care
- ☐ Other - please specify:_____

4. Approximately what does it cost to provide these services? $_____

Of that amount, how much is funded by:

- local funds: $_____
- private donations: $_____
- state funding - non-CDC related: $_____
- CDC funds through the state: $_____
- state funding - non-HRSA related: $_____
- HRSA funds through the state: $_____
- county funds: $_____
- Title V: $_____
- Title X: $_____
- Medicare: $_____
- Medicaid: $_____
- United Way: $_____
- STD programs: $_____
- client fees: $_____
- private foundations: $_____
- faith based: $_____
- other federal grants: $_____
  source:_____
- other: $_____
  source:_____

5. To what groups do you target your education and/or services? Mark all that apply.

Sex	Age	Race
☐ Female	☐ Adults (30+)	☐ Caucasian (not Hispanic)
☐ Male	☐ Young Adults (20-29)	☐ Black/African American (not Hispanic)
☐ Transgender	☐ Adolescents (11-19)	☐ Asian
	☐ Youth (1-10)	☐ Native American/Native Alaskan
	☐ Infants	☐ Native Hawaiian/Pacific Islander
Ethnicity		☐ Other
☐ Hispanic		☐ Unknown
☐ Non-Hispanic		

Specific Target Populations

- ☐ Gay/Lesbian/Bisexual/Transgender
- ☐ Health education workers (i.e. nurses, social workers, etc.)
- ☐ Prisoners/Incarcerated persons
- ☐ Immigrants/Refugees
- ☐ General Public
- ☐ K-12
- ☐ College
- ☐ Other - please specify:_____

6. What geographic area do you serve? Mark all that apply.

- ☐ City/town - please specify:_____
- ☐ Statewide
- ☐ County - please specify:_____
- ☐ Region - please specify:_____

7. What are the three major gaps or barriers in providing education and/or services in your geographic area?

1. _____

2. _____

3. _____

8. Do you collaborate with any other companies/agencies/places of business or individuals to provide your education and/or services? Please list.

_____

_____

_____

_____

9. What kinds of technical assistance, education, or capacity building would assist you in providing your services? Please list.

_____

_____

_____

_____